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ABSTRACT

This paper describes a death education curriculum designed for and field-tested on verbally expressive adults with mental retardation. The Communicating About Loss and Mourning (CALM) curriculum was presented to an experimental group in 8 sessions each lasting 50 minutes. Lectures and group discussions were used to convey information about death and the aging process. The experimental group consisted of 25 randomly selected participants from clients enrolled in a sheltered workshop program. The mean chronological age and intelligence quotients were 35.1 and 49.3, respectively. The control group also consisted of 25 randomly selected participants from clients enrolled in the same sheltered workshop program. The mean chronological age and intelligence quotients were comparable to the experimental group. The control subjects were never introduced to the CALM curriculum nor had they received any prior instruction in death education or grief counseling. Members of both groups were administered an 8-question oral exam. Results indicated that the experimental group's performance was superior and the total percentage of correct exam responses by experimental subjects was statistically greater than that of the control group. This study reveals that adults with mental retardation have a need and can benefit from death education and grief counseling. Recommendations are included for the development and implementation of an appropriate death education program for mentally retarded adults. The 8-question examination is included. (LP)

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Communicating about Loss and Mourning:

Death Education for Persons with Mental Retardation

RC018526

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COMMUNICATING ABOUT LOSS AND MOURNING:

DEATH EDUCATION FOR PERSONS WITH MENTAL RETARDATION

RC 018526

ABSTRACT

The experimental curriculum that is the focus of this investigation was designed for and field-tested on a sample comprised of verbally-expressive adults with mental retardation. Findings from this pilot study involving the implementation of the Communicating About Loss & Mourning (CALM) Curriculum suggested that mentally retarded persons have a need for and indeed can benefit from a formal program of death education and grief counseling.

A distraught and despairing mother of an adult female with mental retardation attended her daughter's annual program planning conference. Beseechingly, she pleaded: "Is there anyone present who can help my daughter cope with my approaching death?" Those professionals seated around the conference table sheeplishly stared at the woman and then at one another in befuddled silence. Regrettably, the terminally-ill parent's poignant question received no reply.

Such reticence regarding the topic of death and dying undoubtedly is as prevalent among practitioners in the field of mental retardation as within the general population. Death education and grief counseling rarely have been recognized to be essential elements of the individual educational plans or habilitation programs of the mentally retarded. According to Deutsch (1985), a variety of reasons exist for the reluctance of special educators and other human service professionals to forthrightly discuss this sensitive subject with students or clients. Erroneously, it has been argued that mentally retarded persons, irrespective of their age, are incapable of comprehending the finality and irreversibility of death. It also mistakenly has been assumed that the mentally retarded are unable to form the emotional bonds and intimate interpersonal relationships which ultimately could culminate in feelings of personal loss and mourning.

Although such rationalizations may serve to simplify the professional responsibilities of practitioners, they conversely can exacerbate the levels of anxiety, distress, and depression experienced by a bereaving student or client. In reference to their responses to death, as in most other aspects of their lives, persons with mental retardation are more like everyone else than they are different. Even though some low functioning individuals may not be able to clearly conceptualize or express their grief, they too will experience some degree of mourning. Howell (1989) has concluded that service providers should never presume their clients do not know about the sorrow that accompanies the loss of a loved one.

In an experiment involving nonhandicapped, early elementary school students, Jenkins and Cavanaugh (1985) discovered that an understanding of human mortality was correlated with advancing chronological age and the acquisition of verbal skills. According to Speece and Brent (1984), the average age at which children begin to acquire a realistic concept of death is between five and seven. Their mature comprehension of human mortality may only be attainable after they have discerned that: (1) death causes the cessation of all life functioning (nonfunctionality), (2) life can not be restored to the deceased (irreversibility), and (3) all living things ultimately die (universality).

The relationship of death conceptualization and age also was examined by Lipe-Goodson and Goebel (1983) in a rare study involving mentally retarded subjects. Findings from this experiment indicated that life experience acquired through aging enhanced the ability of the mentally retarded to understand the meaning of mortality. Evidently, elder persons with mental retardation acquire a more accurate

conceptualization of death than their younger counterparts with comparable cognitive abilities (Seltzer, 1989).

METHODOLOGY

Based upon the results of the aforementioned research, the experimental curriculum that is the focus of this investigation explicitly was designed for and field-tested on a sample comprised of verbally-expressive adults with mental retardation. The Communicating About Loss & Mourning (CALM) Curriculum was presented in eight sessions each lasting for approximately 50 minutes.

The objectives underlying each lesson were accomplished through the implementation of an instructional format incorporating lecture and discussion. Curricular materials consisted of animate and inanimate objects from the surrounding classroom environment as well as pictures and illustrations depicting human aging from infancy through adulthood.

The critical component of each session was a guided group discussion of the individual and shared experiences of students with death. Although the instructor pointedly encouraged students to reveal their personal thoughts and apprehensions, participation was neither cajoled nor coerced. Furthermore, each student was assured that anyone at any time freely could withdraw from the program without explanation or fear of consequences.

Participants in this study randomly were selected from among clients enrolled in a sheltered workshop program. Chronological ages (CA) of the 25 experimental subjects receiving instruction ranged from 22 to 63 and their measured intelligence quotients (IQ) were from 18 to 73. The mean CA and IQ for this experimental group were 35.1 and 49.3, respectively. All experimental subjects possessed sufficient verbal skills to comprehend oral instruction and auditorially express themselves during group discussions.

Additionally, a control group consisting of 25 other verbal clients from the same sheltered workshop program also was randomly chosen. The CA range of control subjects was from 28 to 66 and IQ scores were from from 20 to 66. The group's mean CA was 42.0 and the mean IQ was 48.9. In contrast to their experimental counterparts, control subjects were never introduced to the CALM Curriculum nor had they received any prior instruction in death education or grief counseling.

Following the field testing of the CALM curriculum, members of the experimental as well as the control group individually were administered a brief, eight-question, oral examination. Responses received from all subjects were tallied and the percentages of correct responses were computed for each item of the test. To facilitate further analysis of these descriptive statistical data, responses from the experimental and control subjects were tabulated separately. Thereafter, values were calculated for all test items to ascertain if any significant differences existed between the two groups.

RESULTS

An analysis of the descriptive data derived from the administration of the eight-question examination to all 50 subjects revealed that the experimental group's performance was numerically superior to that of the control group for every single test item (see Table 1). Moreover, the total percentage of correct exam responses by experimental subjects (81.2%) was statistically greater than that of control group members (55.6%) at the .05 level of significance.

In reference to individual test questions, a pattern of comparatively immature and naive responses is evident among members of the control group. Although almost all subjects realized that inanimate objects are incapable of dying, significantly fewer control subjects correctly reasoned that human beings conceivably could perish during infancy. Furthermore, not one of the control subjects apparently could foresee an instance when it would be socially permissible to feel indifferent or undisturbed by the death of another person.

Regarding the question of the examiner's own mortality, sizeable and statistically similar proportions of both groups responded incorrectly. Even after their exposure to the CALM curriculum, almost half of the experimental subjects still could not tell another person directly to his face that he eventually would die.

As compared to their control counterparts, experimental subjects nonetheless exhibited a clearer understanding of the limitations of their own therapeutic powers. A significantly greater proportion of the experimental group correctly concluded that gestures of kindness alone could not revive an aging, ailing grandparent. Significantly more experimental than control subjects likewise realized that more than wishing would be required to resurrect a person from the dead. However, large and statistically comparable majorities of both groups properly inferred that merely desiring someone's demise could not induce that person's death.

Concerning the matter of societal conventions for funerals, significantly fewer control than experimental subjects evidently understood that rules of etiquette exist governing the behavior of mourners. Barely a majority of the control group accurately assumed that it would be socially inappropriate for a person to enter a funeral home merely to determine the identity of the deceased.

Insert Table 1

DISCUSSION

As evidenced by the comparative examination responses of control and experimental subjects, adults with mental retardation have a need for and indeed can benefit from death education and grief counseling.

Simlansky (1987) metaphorically has maintained that the goal of such an instructional program is to cognitively and emotionally immunize students to the concept of death. Applying this medical analogy to the CALM Curriculum, successive lessons may be conceptualized as controlled, incremental doses of distress which are intended to reduce the student's affliction and hasten his recuperation from more severe cases of personal misfortune in the future.

If grieving mentally retarded persons are to be aided in their recovery, practitioners therefore may be called upon to develop an appropriate death education program as an antidote for chronic sorrow. Based upon the finding from this study the following recommendations accordingly are offered to prospective curriculum developers:

1. A community-based instructional approach should be implemented which emphasizes experiential learning within the natural environment. Field trips to area funeral homes, cemeteries and churches should be augmented by guest presentations from morticians, physicians, and the clergy.

2. Community standards of conduct at funeral homes and cemeteries should also be taught. Media presentations of actual or enacted burial rites could serve to illustrate socially acceptable behavior.

3. The knowledge that death is a universal and irreversible outcome of the natural aging process should be conveyed to students during each lesson. At the same time, they should be assisted in understanding that fatal injuries and incurable illnesses suddenly and unexpectedly can shorten the life span of any living being.

4. The social permissibility of public displays of bereavement for a loved one should be understood by students. Conversely, students should be assured that indifference or relief also may be reasonable human reactions to the death of a stranger or long-suffering loved one.

5. Pertinent new vocabulary words should be presented during each lesson. Particular emphasis should be placed on defining and discussing euphemisms for death like passing on, kicking the bucket, and meeting one's maker.

6. Rather than delivering instruction on successive days over a brief period of time, a program of study pertaining to death education may be more meaningful if taught on a weekly basis spanning several months. Every new lesson should be preceded by a review and guided discussion of subject matter from prior classes. Throughout these weekly sessions, students should be encouraged to speak freely about their own mortality as well as that of others.

CONCLUSION

Like all of us, at some point in their lives persons with mental retardation inevitably will encounter the universal human experiences of loss and mourning. Special educators and adult service providers therefore would be remiss in their professional responsibilities if they were to disregard their students' and clients' need for death education and grief counseling. Moreover, as Kubler-Ross (1969) sagely has maintained, those practitioners who are willing to respond to this need may emerge from the experience with fewer anxieties about the approaching demise of their own loved ones - and themselves.

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TABLE 1

Examination of Knowledge and Attitudes about Death

Question	Percentage of Control Group Answering Correctly (n = 25)	Percentage of Experimental Group Answering Correctly (n = 25)
1. Can a chair die?	92	100
2. Can a tiny baby die?	56	84*
3. Is it ever alright not to feel sad when someone dies?	0	80***
4. Will I (the examiner) ever die?	40	52
5. If your old grandmother became very ill, could you keep her alive by being kinder to her?	36	84***
6. If you wished hard enough could you make a dead person come back to life?	48	100***
7. If you wished someone were dead, and that person died the next day, would it be your fault?	76	92
8. If you were walking past a funeral home filled with people, should you go inside to find out who died?	52	88**

*p .05. **p .01. ***p .001.